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		A. BUILDING 00 B. WING	04/02/2013

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R000000	This visit was for a Residential Licensure Survey. Survey dates: April 1 and 2, 2013 Facility number: 004686 Provider number: N/A AIM number: N/A Survey team: Virginia Terveer, RN, TC Sue Brooker, RN Julie Call, RN Census bed type: Residential: 18 Total: 18 Census payor type: Private: 18 Total: 18 Sample: 10 These state findings are cited in accordance with 410 IAC 16.2. Quality Review completed on 04/04/2013 by Brenda Nunan, RN.	R000000	Submission of this response and Plan of Correction is NOT a legal admission that a deficiency exists or, that this Statement of Deficiencies was correctly cited, and is also NOT to be construed as an admission against interest by the residence, or any employees, agents, or other individuals who drafted or may be discussed in the response or Plan of Correction. In addition, preparation and submission of this Plan of Correction does NOT constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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R000241	410 IAC 16.2-5-4(e)(1) Health Services - Offense (e) The administration of medications and the provision of residential nursing care shall be as ordered by the resident ' s physician and shall be supervised by a licensed nurse on the premises or on call as follows: (1) Medication shall be administered by licensed nursing personnel or qualified medication aides. Based on observation, interview and record review, the facility failed to ensure the correct route for insulin administration was used, the accurate documentation for the insulin injection site and for the correct insulin name for 1 of 1 resident observed for insulin administration (Resident #7). Findings include: During observation of insulin administration for Resident #7 on 4-1-13 at 11:50 a.m., LPN #4 administered Humalog Insulin Flexpen, 4 Units in his right trapezius area (the area between the neck and top of the shoulder). The clinical record for Resident # 7 was reviewed on 4-2-13 at 8:50 a.m. Resident #7's diagnoses included, but were not limited to, diabetes, coronary artery disease, chronic obstructive pulmonary disease, and senile dementia of Alzheimer type.	R000241	**R 241 410 IAC 16.2-5-4(e)(1) Health Services - Offense** **What corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice?** Resident # 7 had no adverse effects from receiving insulin in the right trapezius area. An audit of current residents' medication the administration records will be conducted by the Wellness Director or designee to ensure that medications have been administered and ordered per physician orders, as to comply with 410 IAC 16.2-5-4(e)(1). All nursing staff will be re-trained on the five rights of medication administration and the most common sites for injections and proper documentation on the medication Administration Records and Residents Service notes. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** No other residents were found to be affected. **What**	05/01/2013

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	Review of Resident #7's Medication Administration Record (MAR) on 4-2-13 at 8:45 a.m., indicated the insulin was injected into the right deltoid (muscle forming the rounded contour of the shoulder/arm). Record review of Resident # 7's physician order, dated 3-28-13 indicated, "Humalog 100 Unit/ML(milliliter, a measurement) Subcutaneous Solution per sliding scale before meals and HS (bedtime). Use this slide scale as written: BS(Blood Sugar) under 120, no extra insulin,121-150 = 1 unit, 151-179 = 2 units; 180-201 = 3 units; 202-239 = 4 units; 240-269 = 5 units; 270-299 = 6 units; >(greater than) 300 = 8 units, > 350 = 10 units and then recheck in 2 hours; repeat the scale if still over 150..." The physician's order for the Humalog Insulin Sliding Scale was documented in Resident#7's MAR as Novolog. An interview with Wellness Director on 4-2-13 at 9:10 a.m., indicated the area between the neck and top of the right shoulder was not the right deltoid area of the arm. She also indicated, insulin should be given subcutaneous (SQ) in the areas of the abdomen and		**measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur?** A three way audit system is to be instituted as to ensure that residents receive physician ordered medications per physician orders. Al nurses will be inserviced on the proper sites for Sub Q injections. Wellness Director or deignee will monitor administration of insulin weekly for a month, every other week for a month and monthly thereafter. **How will the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** Regional team to review MARs and staff education upon quarterly visitis or when deemed necessary. **By what date will the systemic changes be completed?** May 1, 2013	

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	back of the arms, and the injection sites should be rotated. The Wellness Director provided the facility policy for Medication Management, dated January, 2013, which did not indicate procedure for administering SQ medications nor the appropriate SQ sites. During the interview on 4-2-12 at 9:10 a.m., the Wellness Director indicated SQ sites for injections should have been common nursing knowledge. Review of LPN #4 Medication Pass Competency Checklist, dated 10-26-12, indicated LPN # 4 met competency to correctly complete MARs after passing medications. The 2010 Nursing Spectrum Drug Handbook indicated, "...Subcutaneous drugs injected into the fat pads on the abdomen, buttocks, upper back, and lateral (towards the outside) upper arms and thighs...."			

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R000273	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation, interview and record review, the facility failed to ensure staff washed their hands for the appropriate amount of time and used a paper towel as a barrier to turn off the water faucet in the facility kitchen. The facility also failed to ensure staff washed their hands after touching a visitor and a soiled door handle during the service of meals in the dining room potentially affecting 17 of 18 residents who ate their meal in the dining room. Findings include: 1. During a continuous observation of the lunch meal on 4/1/13 from 11:50 a.m. to 12:23 p.m. in the facility kitchen, the Health Facility Administrator and CNA (Certified Nursing Assistant) #1 were passing bowls of three bean salad, plates of creamed chicken over biscuit and brussel sprouts, and bowls of apple crisp to the residents in the dining room. After several plates of food were passed, they were observed to re-enter the kitchen to retrieve more	R000273	**R 273 410 IAC 16.2-5-5.1(f) Food and Nutritional Services – Deficiency What corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice?** All staff to be inserviced on proper hand washing techniques per 410 IAC 7-24. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** Other residents were found to be affected. **What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur?** Instructions on proper hand washing are in place above the kitchen sink. Resident Director and/or Wellness Director will monitor proper hand washing weekly for a month, every two weeks for a month and monthly thereafter.**How will the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** Regional team to monitor hand	05/01/2013

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	plates of food to pass to residents in the dining room. This process continued until all residents were served their meal. The Health Facility Administrator and CNA #1 were observed to wash their hands each time they entered the kitchen for additional plates of food. The Health Facility Administrator was observed to turn on the water, put soap on her hands, and then immediately place them under the running water for 3 -5 seconds. She was not observed to lather her hands with soap, was not observed to wash her hands for the appropriate amount of time, and was not observed to use a paper towel as a barrier to turn off the water faucet. CNA #1 was observed to turn on the water, put soap on his hands, lather his hands for the appropriate amount of time before rinsing his hands in the running water. He was not observed to use a paper towel as a barrier to turn off the water faucet. At 12:20 p.m., Cook #2 was observed to remove her disposable gloves worn during the service of the meal. She was observed to turn the water on, lather her hands with soap, but only washed her hands for 8 seconds prior		washing compliance upon quarterly visits. **By what date will the systemic changes be completed?** May 1, 2013.	

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	to rinsing her hands in the running water. She then donned a new pair of disposable gloves to prepare a grilled cheese sandwich for a resident who did not like the noon meal served. The Dietary Service Coordinator was interviewed on 4/2/13 at 9:00 a.m. During the interview she indicated dietary staff and facility staff who serve meals should have washed their hands for 30 seconds. She also indicated a paper towel was to be used as a protective barrier when turning off the water faucet. 2. During an observation in the dining room on 4-1-2013 at 12:08 p.m., the Healthcare Facility Administrator patted a visitor on the shoulder and proceeded to serve a resident their meal without washing hands. 3. During an observation in the dining room on 4-1-2013 at 12:10 p.m., the Activity Director touched the door handle with her hand as she was entering the dining room from the kitchen and proceeded to serve residents their meals without washing hands. An interview with the Dietary Service Coordinator on 4-2-2013 at 10:15 a.m., indicated staff should have			

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	washed their hands after touching another person or a soiled surface prior to serving residents their meals. A facility policy "Handwashing", dated 1/1/13, indicated "...Staff should always thoroughly wash their hands in the following situations: Before handling items in the food preparation and handling area...General procedure for proper hand washing: Completely wet your hands...Apply soap...Work up a good lather...Clean for at least 10 seconds...Turn off the faucet with the paper towels... Never touch the faucet with your hands after washing, as the faucet is considered dirty...."			

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R000301	410 IAC 16.2-5-6(c)(5) Pharmaceutical Services - Deficiency (5) Labeling of prescription drugs shall include the following: (A) Resident ' s full name. (B) Physician ' s name. (C) Prescription number. (D) Name and strength of the drug. (E) Directions for use. (F) Date of issue and expiration date (when applicable). (G) Name and address of the pharmacy that filled the prescription. If medication is packaged in a unit dose, reasonable variations that comply with the acceptable pharmaceutical procedures are permitted.			
	Based on observation and interview, the facility failed to label the insulin with open dates for 1 of 2 residents who received insulin injections from the staff nurse. (Resident #7) Findings include: During an observation of medication storage on 4/1/13 at 12:30 p.m., Resident #7's Lantus and Humolog Insulin Flexpens were not labeled with an open date. In an interview with LPN # 4, during the observation of medication storage on 4/1/13 at 12:30 p.m., LPN #4 indicated she was not aware of the date the insulin was opened. During an interview with the Wellness	R000301	**R 301 410 IAC 16.2-5-6(c)(5) Pharmaceutical Services - Deficiency What corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice?** Insulin with no open date noted was discarded. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** No other residents were found to be affected. **What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur?** Wellness Director will retrain all nursing staff on labeling of prescriptions and opened dates on insulin. Wellness Director or Designee will monitor all	05/01/2013

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	Director on 4/2/13 at 9:10 a.m., she indicated insulin without an open date documented on the insulin label should have been discarded. A review of the facility's policy for Medication Management, dated January, 2013 indicated, "...Be alert to the following...Packaging that does not conform to Residence policy....Expired medication...Check the open date...."		medications in the medication cart weekly on an pngoing basis as to comply with 410 IAC 16.2-5-6(c)(5). **How will the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** Regional nurse will audit med cart upon quarterly visits or more frequently if deemed appropriate. **By what date will the systemic changes be completed?** May 1, 2013.	

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R000304	410 IAC 16.2-5-6(e) Pharmaceutical Services - Deficiency (e) Medicine or treatment cabinets or rooms shall be appropriately locked at all times except when authorized personnel are present. All Schedule II drugs administered by the facility shall be kept in individual containers under double lock and stored in a substantially constructed box, cabinet, or mobile drug storage unit. Based on observation and interview, the facility failed to ensure the medication cart was locked while unattended by the nurse, which could potentially affect 12 of 18 independently mobile residents. Findings include: During an observation on 4-1-13 at 12:40 p.m., the medication cart sat in the hallway outside the dining room when LPN # 4 left the medication cart unlocked and unattended to assist a resident from the dining room to the lounge. There were 2 unidentified residents independently walking with their walker by the medication cart when the cart was unlocked. During an interview with the Wellness Director on 4-2-13 at 9:10 a.m., she indicated the medication cart should be locked every time the nurse steps away from the medication cart. The facility's policy for Storage of	R000304	**R 304 410 IAC 16.2-5-6(e) Pharmaceutical Services - Deficiency What corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice?** All nursing staff were re-educated on the requirement of keeping medication cart locked when unattended per 410 IAC 16.2-5-6(e). **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** No Residents were affected. **What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur?** All nursing staff were re-educated on the requirement of keeping medication cart locked when unattended per 410 IAC 16.2-5-6(e). Medication cart will be locked in medication room when no medication pass is in process. The Residence Director and/or Wellness Director will	05/01/2013

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	Medications, effective date of 01-01-2013, indicated, "...All medications stored by the resident must be maintained in a clean, neat, LOCKED, container or area. The medication cart, bins, or cabinet(s) and the Wellness Area should be kept locked when not in use...." The facility's Medication Pass Competency Checklist, dated July, 2012, indicated, "...Does not leave med cart unattended or out of sight/locks the cart before walking away...."		monitor medication cart weekly for 6 months with random audits thereafter. **How will the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** Regional team to monitor properly secured mediation cart upon quarterly visits per 410 IAC 16.2-5-6(e). **By what date will the systemic changes be completed?** May 1, 2013.	